



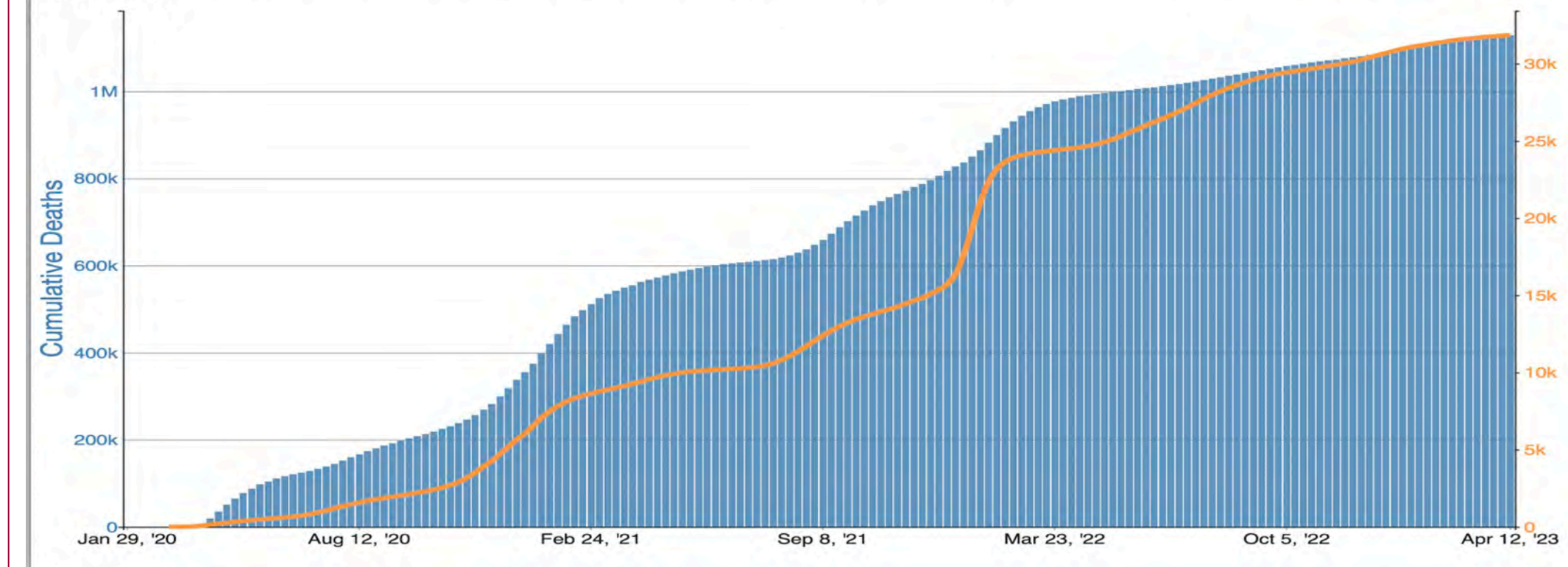
Introduction

Historically, Mass Incarceration has proven to be more dangerous and deadly than Covid. This statement is not meant to downplay the severity of Covid or disrespect those who have lost their lives due to the virus, as it has affected many in my own family. Instead, it sheds light on the detrimental impact that Mass Incarceration has had on communities across America. Given its deadly consequences, I propose that Mass Incarceration be addressed with the same level of urgency and intensity as Covid. It is time to acknowledge Mass Incarceration as a cancer in our society and take immediate action to address it. It also violated the core principles of Bioethics and will not pass any ethical inspection upon closer scrutiny.

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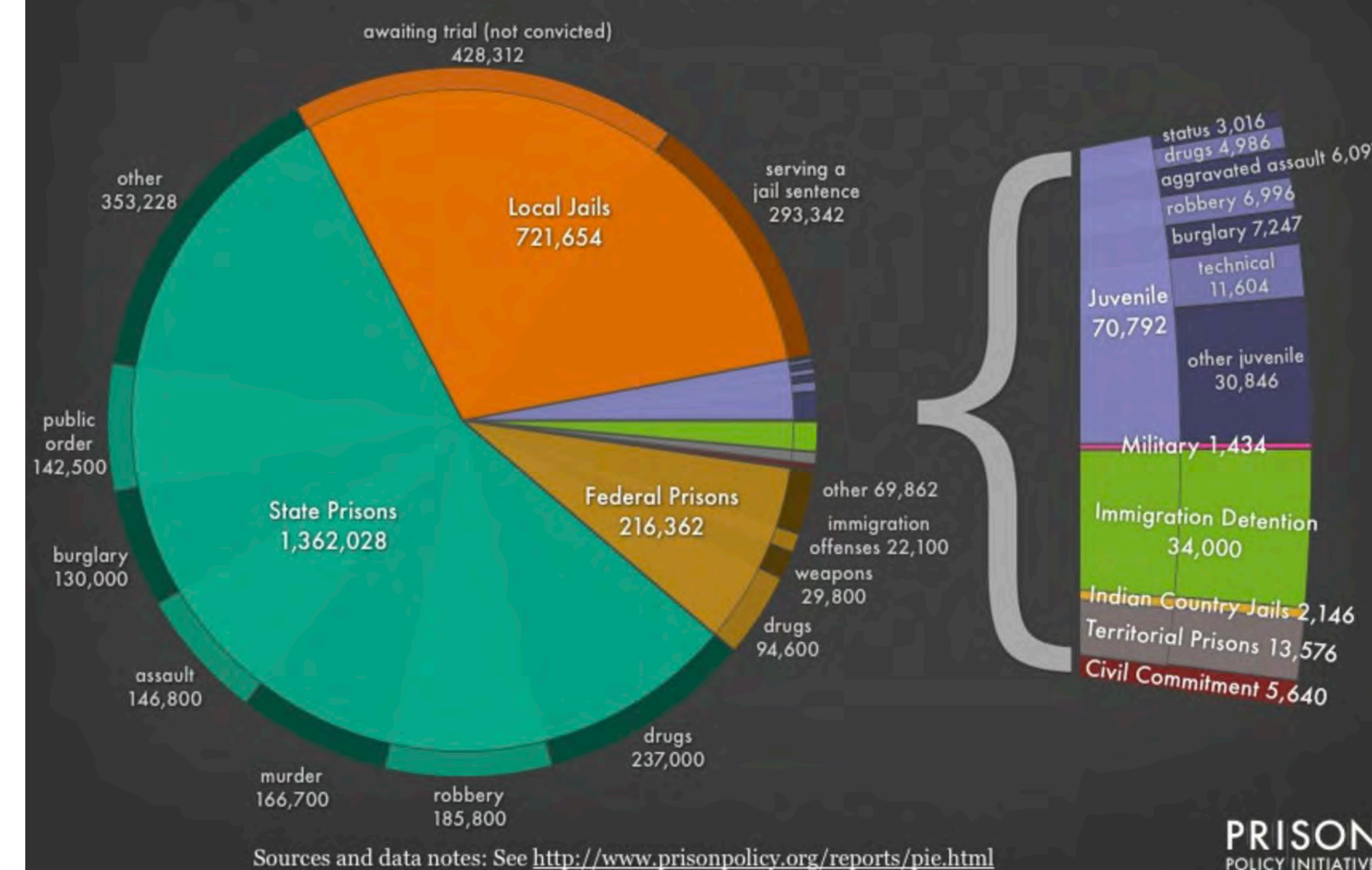
Trends in Total Deaths and Cumulative Incidence Rate of COVID-19 Cases in The United States Reported to CDC, per 100,000 population.



The Disease: Over a period of approximately 1.5 years, from the beginning of the pandemic in late 2019 to September 2021. 4.6 million people died from Covid worldwide. (WHO, 2021) Meanwhile every year 2.2 million people suffer from incarceration. About 4 million are on parole or probation. (Sawyer and Wagner, 2020) And then when u think about all the families affected and the people in the community affected this pandemic is just as serious.

How many people are locked up in the United States?

The United States locks up more people, per capita, than any other nation. But grappling with why requires us to first consider the many types of correctional facilities and the reasons that people are confined there.



The Cure

- Substance Use Tx
- Wage Gap
- Cure Violence Approach
- Redefining as a health issue
- Legal reform
- Agency
- Improve Data
- Legal Reform



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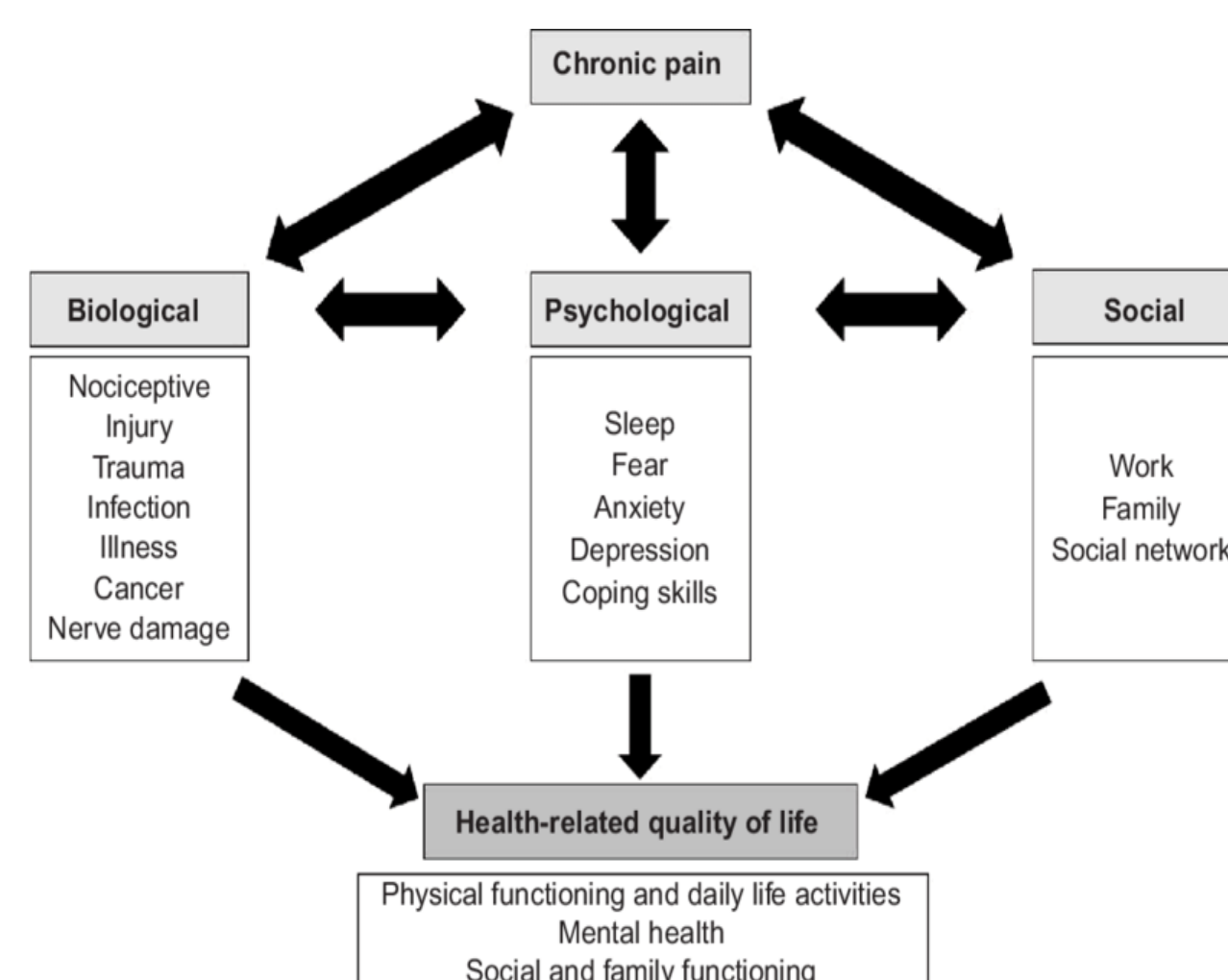
Chronic pain

Chronic pain is a national public health problem. Poor availability of treatment leads to increased costs, unnecessary suffering for patients, and a significant economic burden on society

A 2020 analysis of National Health Interview Survey data by the Centers for Disease Control and Prevention (CDC) found that 20.5 percent (50.2 million) of adults in the United States suffered from chronic pain, and 10 percent of adults (24.4 million) had severe chronic pain with work limitations. Women had the highest incidence of chronic and severe high-impact chronic pain. Also, patients who resided in more remote and rural locations were more likely to experience chronic pain.

Biopsychosocial Model

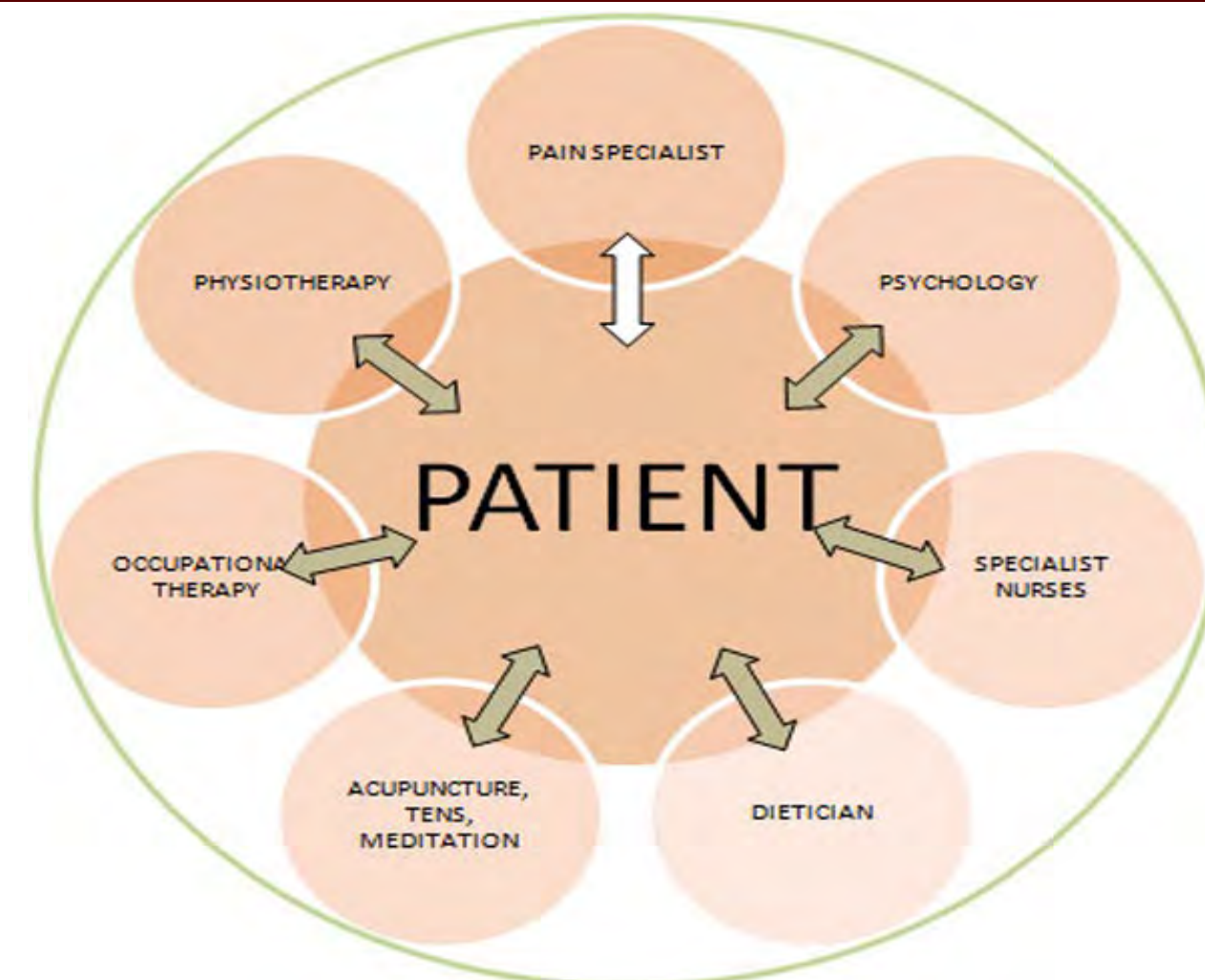
The biopsychosocial model focuses on the physiological, psychological, and social elements that prolong and potentially exacerbate the pain experience. Pain management requires a multidimensional, structured assessment and ethical treatment that addresses biopsychosocial concerns rather than the simpler biomedical model of diagnosis and treatment that is often effective for short-term or acute pain.



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Multidisciplinary Pain Management



Through the biopsychosocial model, multidisciplinary pain management takes a more holistic approach to treating chronic pain. Rehabilitation rather than cure is the predominant therapeutic objective.

In multidisciplinary pain management programs, patients are often treated in group sessions in an outpatient setting. This group setting allows participants to learn from one another's experiences and normalize living with chronic pain. For effective care several healthcare specialists must work together, including but not limited to physicians, nurses, psychologists, physical therapists, occupational therapists, vocational counselors, social workers, and support staff, to address all aspects of the pain experience. The sessions cover physical, psychological, medical, and career-related themes. Programs frequently prioritize individual and group therapy, physical exercise, medication management, learning coping and vocational skills, and education on pain and body physiology, depending on the patient's needs.

This treatment has been shown to reduce pain, decrease the need for or elimination of inappropriate medication, decrease healthcare utilization, increase physical activity, increase return to work, decrease iatrogenic complications, and improve patient satisfaction.

Telehealth To Improve Accessibility

Studies have suggested a benefit for chronic pain treatment through telehealth and online platforms, which could improve accessibility to treatment for chronic pain patients.

The Reboot Program was a trial done in Australia which was a 16-week online course to study the possible benefit of online multidisciplinary pain management. Participants were able to access these lessons whenever it was convenient for them. The courses covered material from various medical specialties, including radiology, psychiatry, anesthesiology, rheumatology, pain medicine, rehabilitation medicine, and other health specialties, such as occupational therapy.

Participants in the Reboot online group, who completed the program, revealed gains in pain self-efficacy, pain intensity, movement-based fear avoidance, pain-related disability scores, psychological distress, and anxiety compared to the control group. At the three-month follow-up, these advancements in the online treatment group were still present.

There are few studies on the efficacy of online multidisciplinary care, but this one makes a compelling case for its efficiency. These positive results have significant therapeutic ramifications for efficiently treating chronic pain. More work must be done to prove the efficacy of this type of care.

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Introduction

Lifetime incarceration in the United States has an incidence of 6.6%, the highest globally. Within the US, individuals experiencing incarceration are among the few citizens who have a protected right to healthcare, as outlined by the Eighth Amendment of the Constitution. Yet, despite the promise for adequate care, patients who are currently or have previously experienced incarceration continue to be included in the most vulnerable and underserved populations. When bioethical principles, specifically autonomy and agency, are considered, the relationship between the healthcare system, the criminal justice system, and the individuals who are having to navigate both sides becomes very convoluted. Incarceration itself is often associated with poor short- and long-term health outcomes, and patients who are currently or previously experienced incarceration can face bias when attempting to navigate the healthcare system. It is imperative to evaluate healthcare provided in jails and prisons, as well as in the hospital, to these patients and their associated outcomes. This project explores the current state of healthcare provided to individuals who are currently or previously incarcerated in an attempt to identify disparities in the provision of this care, as well as offers potential solutions to provide more ethical and

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Care Provided in Correctional Institutions

- There are no required universal standards about what kinds of care must be offered in these facilities
- Arrests are disproportionately concentrated in communities who are already likely to be medically underserved as a result of systemic racism, discrimination, and other social determinants of health
- There are high rates of chronic health conditions, such as hypertension, asthma, and arthritis in prison and jail inmates
 - About half of all prison and jail inmates report having a chronic health condition
 - Loss of freedom of choices about diet, exercise, and personal medical management
- There are higher rates of mental illness and substance use disorder in incarcerated individuals than non-incarcerated individuals with lack of infrastructure to support treatment
 - Pre-existing mental health conditions are prevalent, and many individuals develop new mental health symptoms while incarcerated and exposed to stressors and trauma
 - 58% in state prisons and 63% in local jails met criteria for “drug dependence or abuse”
 - Still a lack of access to treatment, especially Medication Assisted Treatment for substance use disorder remains

Care Provided in Hospitals

Shackling

- Using handcuffs or chains, to control movements of the body
- Risks: increased falls, reduced mobility, prevent physical exam
- Lack of guidance for HCWs on appropriateness of shackles

HIPAA

- When guards are present, there is risk of inadvertent disclosure of patient private health information
- Patients may not feel comfortable disclosing parts of health history (substance use, sexual history) with guards present

Bias

- Incarcerated patients are exposed to conscious and unconscious bias
- HCWs being aware of the crime a patient is accused of can introduce bias into the care provided

Transition to Care After Incarceration

- Over half a million individuals are released from prisons and millions more are released from jail each year
 - Many return to communities that are experiencing social and health inequities at disproportionate levels
- Individuals receiving treatment for chronic conditions during incarceration often lose access to that care upon release
- It is difficult to access a PCP or insurance after incarceration, so individuals often use expensive ED visits as primary care
- The “re-entry” period after release from incarceration is a very dangerous time, especially for individuals with substance use disorder
 - Mortality rate in the first 2 weeks after release is estimated to be 13x higher than other residents in the same area who were not incarcerated

Potential Solutions

- Required national standards for care in the correctional facility setting to regulate quantity and quality of care, including mental health and substance use treatment
- Shackling policies in hospitals that mimic existing restraint policies - least restrictive form of restraint that keeps both patients and healthcare teams safe
- Additional privacy precautions when discussing private health information with patients in hospital rooms where guards are present
- Transition clinics to ensure safe follow up for patients who are returning home from incarceration
- Medicaid as insurance coverage during transition period

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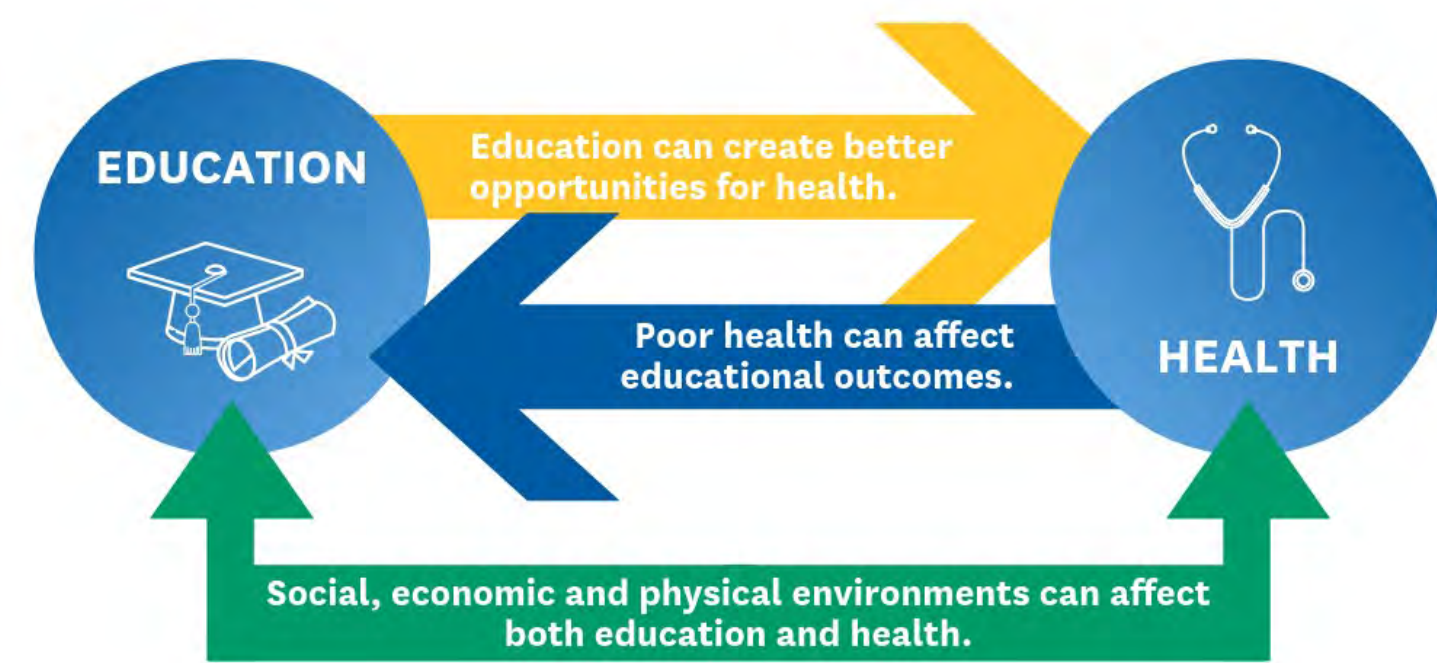
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Introduction

RISE (Remote Interpersonal Student Education) is a nonprofit made up of medical students. Arising during the start of the pandemic, the goal was to connect with inner city K-12 students who were struggling to adapt to the online learning environment through video conferenced tutoring and mentorship sessions. In this paper, I intended to goal is to describe how RISE currently interacts with the school district and how future directions of these relationships may benefit from examination through an urban bioethical lens. To write this report, I drew on coursework, additional research, and semi structured interviews I conducted with various

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Challenges:

- As COVID normalized, in person tutoring was desired
- Imbalance in numbers of tutors and students
- Communication break down
- Lack of trust

Solutions:

- Shift to hybrid model
- Early planning (in summer before school year begins)
- More flexibility in communication modality
- Community member board in parallel leadership structure

Social Determinants of Health



Empowering Through Agency

Core bioethical principle of autonomy...

- Hotze (2011): the school and AMC both shape
- We need to let them drive the bus and we supply the fuel
- Wilkins and Alberti (2019): shared decision making
- LeChausser (2014): community driven vs based

Urban bioethics urges us to take one step further! **Moving from honoring autonomy to facilitating agency.**

- Autonomy means that the community has the right to decide which (if any) intervention it receives. Agency elevates the onus of the researcher and the academician to ensure that the community is making an informed decision.
- This practice involves assessing the way the community best ascertains new information and packaging the materials accordingly. Facilitating agency also entails gathering the appropriate stakeholders so that the group deciding represents the whole community's interests.

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Introduction

This thesis is an original pilot analysis which focuses on physicians from Afghanistan who were evacuated due to the Taliban takeover in 2021. Through participant interviews, I examine the challenges and opportunities facing these physicians who are attempting to re-enter the medical field in their new home, the United States.

Overview of U.S. Medical Licensure:

- An international medical graduate (IMG) must have proof of a medical degree from their country of training, pass Step 1 and Step 2 of the United States Medical Licensing Exams, obtain Educational Commission for Foreign Medical Graduates certification, and successfully match into a residency position in order to practice medicine¹
- In 2022, the residency match rate for non-U.S citizen IMGs was 58.1%²
- The U.S faces a projected shortage of between 37,800 and 124,000 physicians by 2034³

With the physician shortage and the recent influx of over 70,000 Afghan evacuees who have been paroled into the United States, I argue that the skills of Afghan medical doctors are essential to their new homeland. Afghan physicians have the medical expertise as well as cultural and linguistic skillset to care for the new Afghan diaspora and the general population. This thesis aims to illuminate the voices of those with life-saving skills who are unable to use them and advocate for increasing workforce

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Methods

This pilot analysis draws on a total of 6 participant interviews that were conducted in February and March of 2023. Subjects were recruited from an email list of attendees who participated in a conference hosted by the Afghan Medical Professionals Association of America (AMPAA):

- AMPAA organized a conference in September 2022 in Fairfax, Virginia that was tailored toward medical professionals from Afghanistan looking to re-enter the U.S. medical field.
- 5 recently resettled physicians and 1 AMPAA board member were interviewed via Zoom or phone call.

The criteria for inclusion were physicians who identified as Afghans that completed medical school in Afghanistan and were looking to re-enter the medical field in the United States.



<https://www.ampaa.org/>

Preliminary Results

In speaking with 5 Afghan physicians who were recently relocated to the United States, common obstacles in re-entering the medical field were identified. A few are listed below:

Economic Burden

“You need to prepare for years, and you need income to pay your bills. You need to work and won’t find time to study.” – a participant

There is an economic cost in re-entering the medical field. Participants pointed to a dilemma between taking dedicated time to study for board exams and working to support their family. One participant verbalized the dilemma of pursuing the medical profession: “If I go for medical, I need to study 8 hours a day so how will I pay for my bills? Should I go to medical or select another profession?... I don’t know what to do.” Thus, the time needed to obtain medical licensure requires financial stability.

English Proficiency

4 of 5 participants studied English during medical school, however all participants felt that their English was a barrier in re-entering the medical field. Participants felt that the fluency required to practice was that of a native English speaker.

Lack of Guidance

Another obstacle is a lack of guidance that is individually tailored. Participants face difficulty in navigating the complex medical system and understanding different career paths within the U.S. healthcare system.

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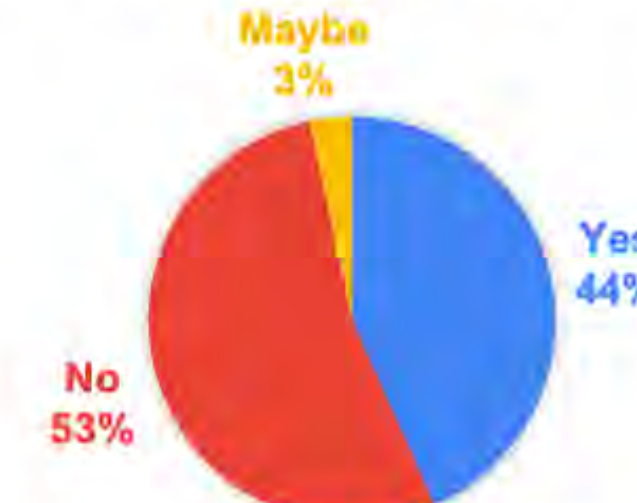
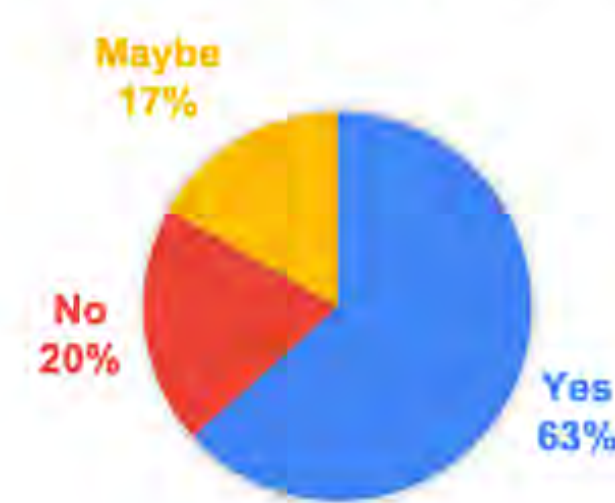
Introduction

Throughout the past few decades, as global health trips for undergraduates and medical students began to increase in popularity, so did the topic of global health ethics. While there has been much research on the regulations for medical students' global health experiences, the same cannot be said for their undergraduate counterparts (Mccall & Iltis, 2014). Given the numerous pre-medical students attending these trips, it is vital to understand their motivations and bring light to the ethical issues that might occur. Intense literature analysis and a global health survey completed by students at the Lewis Katz School of Medicine were used to weigh the benefits against the costs of these trips. Comparing undergraduate global health trips to medical school trips shows that there may be steps that can be taken to improve trips and avoid significant ethical issues.

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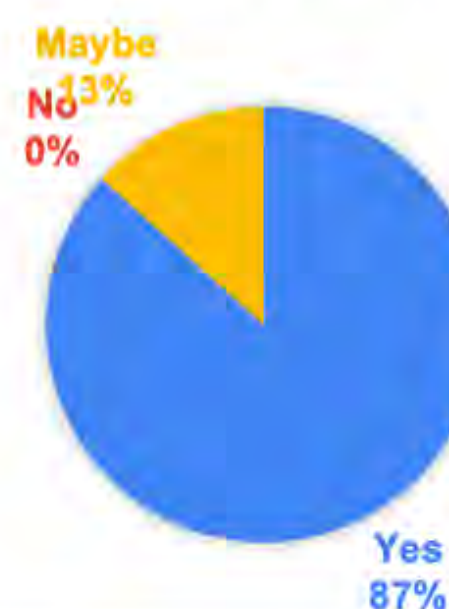
Do you think there are ethical concerns regarding pre-med undergraduate volunteer/shadowing trips abroad? When you shadowed/volunteered abroad did you see people taking pictures of patients without consent?



Survey Conclusions

- The survey data highlighted that medical students believe ethical concerns exist on undergraduate global health trips.
- Some of these ethical concerns included taking photographs without consent, disrespecting local staff due to a lack of education, and students practicing above their training level by performing tasks such as suturing and delivering babies.
- Despite concerns over the ethics of these trips, a majority reported that they benefited.
- Students reported that they better understood barriers to care and were more culturally competent following their experiences.

Do you feel like this trip was beneficial for you as a student?



Where do we go from here?

There are additional challenges regulating undergraduate global health trips compared to trips at the medical school level. This is due to the fact that medical schools are able to approve or deny trips for their students, while this is a much more difficult task prior to medical school (Lasker et. al, 2018). This is due to the wide range of groups that organize global health trips for undergraduates and the lack of standard regulations for these trips (Roble et. al, 2019). Using the medical school model as an example, undergraduate universities as well as the Association of American Medical Colleges (AAMC) could vet and post approved programs for their pre-medical students. These programs would have two main components that would help mitigate ethical missteps - extensive pre-trip orientation and adequate on-site supervision (Raine, 2017). These endeavors, alongside increased efforts to inform undergraduates about the ethical problems associated with global health, would allow students to gain meaning from their trip while minimizing ethical costs to the country and themselves.

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Abstract

BACKGROUND/RATIONALE: Persons with intellectual and developmental disabilities (pIDD) face barriers to quality health care, including psychiatric care, that result in worse health outcomes. While the mental healthcare community is increasing attention towards the psychiatric needs of pIDD, there continues to be a deficit of knowledge regarding psychiatric conditions, including suicidality. Engaging in community-based participatory research (PAR) with pIDD is the ethical way to address these deficits. An academic researcher (AR) must first educate herself on lessons from disability rights activism and disability bioethics. **OBJECTIVE:** Apply the intertwining history and principles of disability rights movements and disability bioethics to lessons learned from previous PAR with pIDD in order to propose principles that can guide research investigating psychiatric conditions in pIDD.

METHODS/APPROACH: Research focuses on landmark texts in disability rights movements and disability bioethics. Lessons learned from previous PAR is mostly obtained from reflexive accounts on behalf of the AR and outside of psychiatry.

RESULTS: The AR must understand the history of society valuing non-disabled lives over disabled lives, inclusive of pIDD, and the social model of disability as it relates to the human variation model. When engaging with pIDD, the AR can question the traditional definition of vulnerable populations, challenge the group to progress beyond informed consent, continually support a capacity-building approach to research and power-sharing skills, and embrace empowerment to enact political change.

DISCUSSION: ARs, pIDD, and pIDD advocates must not accept the dearth of knowledge regarding psychiatric conditions, including life-threatening suicidality, in pIDD. We should prioritize PAR with persons with pIDD to elucidate psychiatric conditions in pIDD that result in more efficacious and compassionate treatment. This proposal outlines major principles through which the AR can move forward in ethically engaging in PAR with pIDD.

BIOETHICS

- 1947: The Holocaust → Nuremberg Code
 - Must be freely consenting to research
 - 1964: Declaration of Helsinki
 - Proactive document that wasn't directly associated with the Holocaust
 - 1979: Tuskegee → Belmont Report
 - Tuskegee experiments 1932-1972
 - (Why didn't they end in 1947?)
- And maybe some will know of ...
- 1983: AIDS Crisis → Denver Principles
 - People with AIDS are worthy of living

DISABILITY BIOETHICS

- 1947: The Holocaust → Nuremberg Code
 - "Disability bioethics understands that Nazi medicine and Nazi social and political policy merged traditional disability and illness categories with ethnic categories" (Garland-Thompson)
- 1964: Declaration of Helsinki
- 1979: Tuskegee → Belmont Report
 - Willowbrook: 1963-1966, children with pIDD intentionally infected with hepatitis
- 1983: AIDS Crisis → Denver Principles
- 1990: The Americans with Disabilities Act
 - Civil rights for "vulnerable" populations

GOING BEYOND INFORMED CONSENT

- Consent versus Assent: people deemed to have capacity can give consent while those deemed lacking capacity may give assent, which is agreeing while a caretaker with capacity formally consents. People with IDD are often deemed to lack capacity to consent in a non-negotiable manner.
- Community Agreements are a proposed replacement for the traditional consent process. These more wholly invite stakeholders, inclusive of academic and community researchers, pIDD and their caretakers, to the table. Diverse opinions and perspectives are shared, heard, and the group works collaboratively to agree upon the rules of engagement.

SOCIAL MODEL OF DISABILITY

Frames disability in the context of a society that *disables* a person by oppressive measures, rather than something inherently inferior within an individual who is disabled by society.

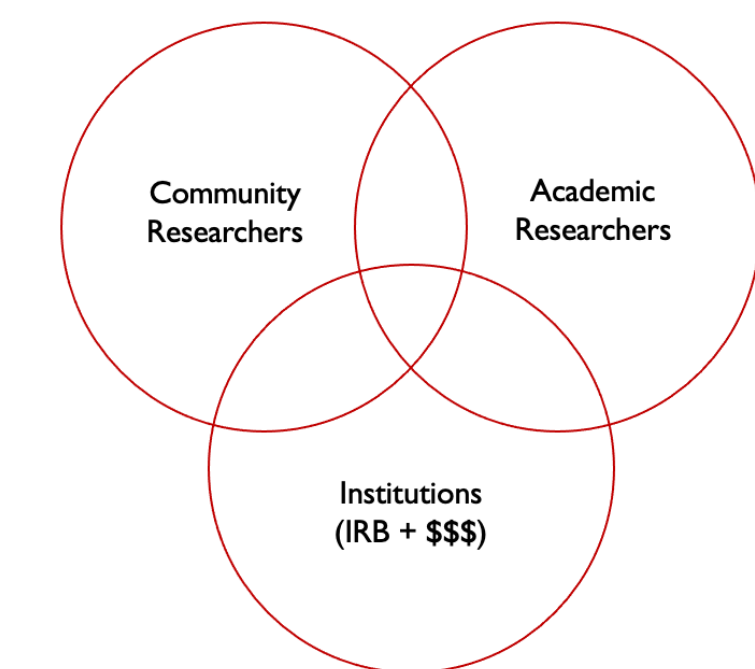
Associated with Michael Oliver

HUMAN VARIATION MODEL

Frames disability as the "systematic mismatch between physical and mental attributes of individuals and the present (but not the potential) ability of social institutions to accommodate those attributes."

Associated with Shriner and Scotch

CAPACITY-BUILDING APPROACH



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“VULNERABLE POPULATIONS”

- Lack of legal rights that vulnerable populations often face while simultaneously being "protected" in research.
- The medical model of vulnerability is an iteration of the problematic medical model of disability.
- Reject this model as we move toward a human variation model of vulnerability where systems that oppress people are scrutinized and changed.

EMPOWERMENT → POLITICAL CHANGE

INCLUSIVE RESEARCH

EMANCIPATORY RESEARCH

PARTICIPATORY RESEARCH



Image 1: A patient gets their fundus photo taken. *Google Images*

Introduction

- The COVID-19 pandemic caused clinicians and patients to reconsider healthcare resource utilization and communication methods.
- The pandemic catalyzed changes in the screening process for diabetic retinopathy, and this disease highlights the impact of social determinants of health on diabetic care and outcomes.
- During the pandemic, ophthalmologists and patients had to assess the risks and benefits of routine screenings, and patients with diabetes had to weigh the risks of a physical trip to the doctor's office.
- Early treatment and intervention for diabetic retinopathy can be vision-saving, but the onset of complications is slow, and routine screening visits often do not result in a change in management or diagnosis for many years.
- There were serious risks and uncertainties around the coronavirus pandemic, particularly for the overlapping demographic at risk for diabetic retinopathy.

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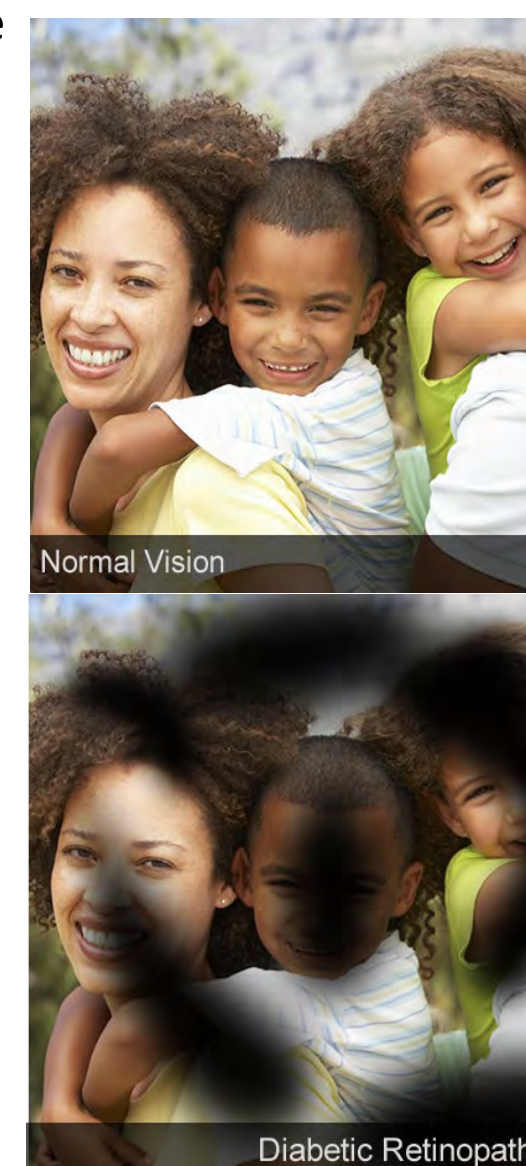
Diabetic Retinopathy Screening

- Diabetic retinopathy is an eye disease caused by chronically elevated blood sugar levels in patients with diabetes that can lead to blindness.
- Guidelines for care set forth by the Diabetes Control and Complications Trial (DCCT) include managing diet, exercise, medications, sleep, weight, regularity in monitoring, and adherence to treatment.
- Diabetic retinopathy severity can indicate poor glycemic control, according to prior studies.
- Socioeconomic status can impact access to care and ability to manage these factors.
- Access to (or lack thereof) basic needs and technology can greatly impact health outcomes.
- Higher out-of-pocket costs for medication can lead to skipping doses and worse outcomes.
- Food insecurity and food deserts limit access to healthy diets.

Temple Ophthalmology Study

Image 2: A dramatization of how diabetic retinopathy can affect the visual field. *Google Images*

- A study by Temple University Hospital reviewed 15 months of data on diabetic retinal screening using telemedicine.
- They found that while the screening program successfully identified patients who needed further evaluation and treatment, a significant proportion (95%) did not follow up for an eye exam.
- The study raises ethical concerns from both a consequentialist and deontological perspective regarding the program's ability to improve patient outcomes and fulfill the duty to provide appropriate care.



Urban Bioethics Analysis

- Regular annual screening exams may not lead to meaningful improvements in vision for every patients every visit
- The DCCT showed some benefits of intensive blood glucose control in reducing complications in patients with type 1 diabetes. However, it has limitations in its applicability to type 2 diabetes and in its diversity among participants
- Screening exams require time, resources, and personnel to administer and interpret results
- A consequentialist risk-benefit analysis could be made in favor of reducing the frequency or necessity of these screening exams, redirecting resources towards more effective interventions that improve patient outcomes and satisfaction,

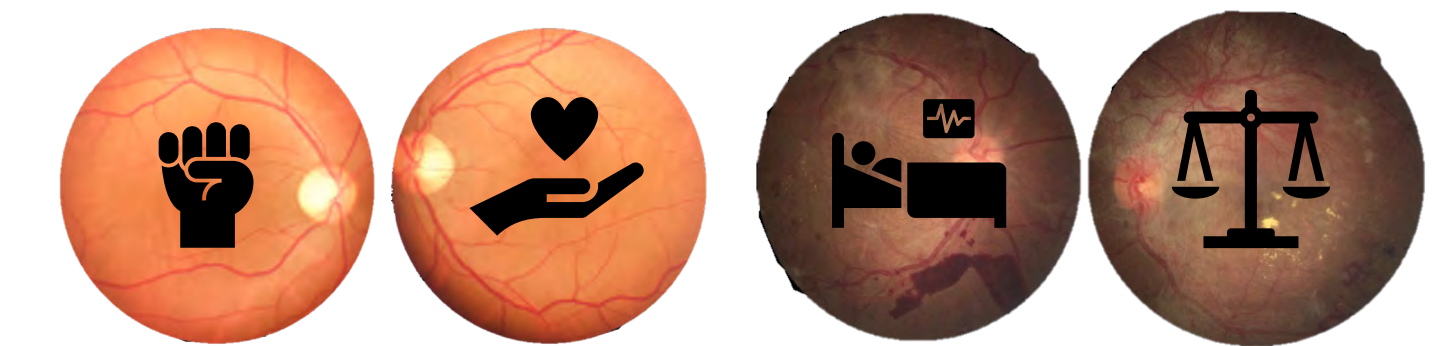


Image 3: Normal fundus photos (left) compared to diabetic retinopathy complications (right), with icons of bioethical principles superimposed. *Google Images*

- Urban bioethics view the principles of agency, beneficence, non-maleficence, and distributive justice with explicit consideration of social determinants of health.
- Urban populations face significant barriers to accessing healthcare, including transportation, time off work, and cost of care. Racial and ethnic disparities also play a role.
- Encouraging primary care engagement in diabetic retinopathy screenings and glycemic control aligns with the principle of solidarity in bioethics, and in fulfilling the duty of a physician.
- By refocusing resources to the primary care setting, we could ensure that all individuals have access to diabetic retinopathy screenings and other cutting-edge technologies.

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